

*Plastic Surgery Associates of Tulsa*

6585 South Yale, Suite 1020, Tulsa, Oklahoma 74136 Phone (918) 481-2900 Fax (918) 481-2985

. DAVID M. CRAIG, M.D. PALMER R. RAMEY, JR., M.D.

**PATIENT MEDICAL HISTORY FORM**

NAME \_\_\_\_\_ AGE \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ ALLERGIES: \_\_\_\_\_ DRUG: \_\_\_\_\_  
REACTION: \_\_\_\_\_

ALLERGIES: DRUG: \_\_\_\_\_ REACTION: \_\_\_\_\_

REASON FOR YOUR VISIT  
TODAY: \_\_\_\_\_

CURRENT MEDICATIONS: DOSE: REASON:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IS THERE VIOLENCE IN YOUR HOME? NO \_\_\_ YES \_\_\_

DO YOU EVER FEEL AFRAID? NO \_\_\_ YES \_\_\_

DO YOU TAKE ASPIRIN, MOTRIN, ADVIL, IBUPROFEN OR ANY MEDICATIONS CONTAINING THESE DRUGS?

NO \_\_\_ YES \_\_\_  
AMOUNT \_\_\_\_\_

DO YOU SMOKE? NO \_\_\_ YES \_\_\_

**CHECK IF YOU HAVE EVER HAD:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> ARTHRITIS            | <input type="checkbox"/> GYN PROBLEMS        | <input type="checkbox"/> ULCERS           |
| <input type="checkbox"/> BLEEDING DISORDER    | <input type="checkbox"/> HEART PROBLEMS      | <input type="checkbox"/> URINARY PROBLEMS |
| <input type="checkbox"/> CHRONIC LUNG DISEASE | <input type="checkbox"/> HEPATITIS           | # OF PREGNANCIES _____                    |
| <input type="checkbox"/> COLON PROBLEMS       | <input type="checkbox"/> HIGH BLOOD PRESSURE | # OF CHILDREN _____                       |
| <input type="checkbox"/> DIABETES             | <input type="checkbox"/> THYROID DISEASE     |   |

PREVIOUS SURGERY (PLEASE GIVE  
YEAR): \_\_\_\_\_

PRIMARY CARE PHYSICIAN:  
\_\_\_\_\_  
First Last City Phone Number

**HAS ANY MEMBER OF YOUR FAMILY EVER HAD:**

- |  |  |                                   |  |
|--|--|-----------------------------------|--|
| <input type="checkbox"/> BLEEDING TENDENCY | <input type="checkbox"/> BREAST CANCER | <input type="checkbox"/> DIABETES | <input type="checkbox"/> HEART DISEASE |
|--|--|-----------------------------------|--|

DO YOU HAVE DIFFICULTY WITH EYES OR  
VISION? \_\_\_\_\_  
(other than wearing glasses)

WHEN WAS YOUR LAST:  
COMPLETE PHYSICAL \_\_\_\_\_ RESULT \_\_\_\_\_  
ELECTROCARDIOGRAM \_\_\_\_\_ RESULT \_\_\_\_\_  
CHEST X-RAY \_\_\_\_\_ RESULT \_\_\_\_\_  
MAMMOGRAM \_\_\_\_\_ RESULT \_\_\_\_\_

PATIENT S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

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PLEASE LIST ANY OTHER PERTINENT MEDICAL HISTORY: \_\_\_\_\_

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PATIENT S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_